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Supreme Court, U.S.
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No. 85-810

IN THE

SUPREME COURT OF THE UNITED STATES

October Term 1985

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, and the BOARD OF TRUSTEES thereof; and MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS DRUG AND MERCANTILE EMPLOYEES WELFARE FUND, and the BOARD OF TRUSTEES thereof,

Petitioners,

v

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED FOR REVIEW

DOES THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) PREEMPT §§ 3425 AND 3609a(2) OF THE MICHIGAN INSURANCE CODE WHICH PROVIDE THAT INSURANCE COMPANIES MUST INCLUDE COVERAGE FOR SPECIFIED SUBSTANCE ABUSE TREATMENT IN THEIR HEALTH AND GROUP DISABILITY POLICIES?

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STATUTES INVOLVED

The pertinent language of §§ 3425 and 3609a of the Michigan Insurance Code, MCLA 500.3425 and 500.3609a; MSA 24.13425 and 24.13609a, as added by 1980 Public Acts of Michigan 429, along with the pertinent language of § 514 of ERISA, 29 USC 1144, are set forth in the Appendix, pp 1a-6a.

STATEMENT OF THE CASE

Respondents agree, in general, with Petitioners' statement of the case. Two points, however, deserve clarification.

First, there has never been any determination that Petitioners' allegations in the Complaint are true. Respondents filed a motion to dismiss in response to the Complaint. Petitioners responded with a motion for summary judgment accompanied by two affidavits which merely stated that the allegations of the Complaint were true. Respondents countered with affidavits pursuant to FRCivP 56(f) stating that since none of the Respondents knew anything about Petitioners' factual allegations, they could not produce affidavits contradicting those Petitioners filed. The issue was brought to the district court's attention during oral argument, but the district court failed to acknowledge that the allegations were unproven. There was no trial. The district court made no findings of fact. Respondents never admitted the validity of Petitioners' allegations. Respondents raised this issue on appeal to the Court of Appeals, but the Sixth Circuit understandably did not address the issue since it reversed the district court on the law. Therefore, this case comes to this Court based only on the untested allegations of the Complaint. Respondents have not, and do not here, admit that those allegations are true. Respondents simply do not know.

Second, whether by design or otherwise, Petitioners have misleadingly characterized their contractual relationship with Transamerica. Petitioners' "Question Presented" suggests they were uninsured plans which then purchased stop loss coverage from Transamerica. Moreover, they repeatedly assert that they process and approve claims, as though Transamerica were disinterested in that aspect of their arrangement. Both characterizations contradict Petitioners' own documents.

Petitioners' connection with Transamerica did not begin with the execution of the Flexible Funding Plan Agreements (FFPAs) in 1982. For literally years prior thereto and continuing up to the time the FFPAs were executed, Transamerica insured the plan benefits under group insurance policies. These policies are referred to in, and are amended by, the FFPAs. Under the group policies, Transamerica collected premiums from Petitioners from which it paid the benefits specified in the group policies. The FFPAs altered this arrangement by providing that benefits would be paid from funds held in Petitioners' names, rather than from the premiums Transamerica received from Petitioners. Because Michigan law was changed in December 1981 to exclude administrative service contracts from the gross premium tax, execution of the FFPAs in 1982 permits Transamerica to avoid the gross premium tax on the money used to pay claims below the claims liability limit.

Under the terms of the FFPAs, Transamerica continues to have final authority to approve and deny all claims and the responsibility to defend suits resulting from denial of claims. The group insurance policies continue to define the existence and limits of the benefits, both above and below the claims liability limit. Thus Transamerica controls its ultimate profit or loss exactly as it would if the FFPAs did not exist.

This clarification is significant because it is clear that, even after the execution of the FFPAs, (1) Petitioners are insured by policies issued by Transamerica and (2) the policies continue to control the granting and the limits of the benefits. Respondents contend that Michigan law requires that Transamerica include in these policies the mandated substance abuse treatment coverage.

ARGUMENT

A. INTRODUCTION AND SUMMARY—THIS STRAIGHTFORWARD ISSUE WAS CORRECTLY DECIDED BY THE COURT OF APPEALS FOR THE SIXTH CIRCUIT BASED ON THIS COURT'S DECISION IN METROPOLITAN LIFE INSURANCE CO V MASSACHUSETTS.

Sections 3425 and 3609a(2) of the Michigan Insurance Code[1] require insurers offering health or group disability policies in Michigan to include in the policies specified coverage for substance abuse treatment. Petitioners allege they are employee benefit plans subject to ERISA who purchase health insurance policies from Transamerica Occidental Life Insurance Company. They claim Michigan cannot compel Transamerica to include the mandated coverage in Petitioners' policies because ERISA preempts state regulation of ERISA employee benefit plans. Respondents contend, and the Sixth Circuit agreed, that §§ 3425 and 3609a(2) are saved from preemption by § 514(b)(2)(A) of ERISA,[2] as laws which "regulate insurance."

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[1]

MCLA 500.3425 and 500.3609a(2); MSA 24.13425 and 24.13609a(2), as added by 1980 Public Acts of Michigan 429. These sections appear in the Appendix, *infra*, pp 1-a to 4-a.

[2]

29 USC 1144(b)(2)(A). This section is reproduced in the Appendix, infra, p 4-a.

While the instant case was pending before the Court of Appeals, this Court decided *Metropolitan Life Insurance Co* v *Massachusetts*, 471 US —; 105 S Ct 2380; 85 L Ed 2d 728 (1985). In a unanimous decision, this Court held that a Massachusetts law mandating coverage for treatment of mental illness in insurance policies was saved from preemption by § 514(b)(2)(A) as a law which regulates insurance. Thereafter, the Sixth Circuit correctly concluded that the *Metropolitan Life* decision controlled this case. In short, if Massachusetts' mandated mental illness treatment coverage was not preempted, then Michigan's mandated substance abuse treatment coverage was not preempted. The Court of Appeals' conclusion was both obvious and correct: if Petitioners elect to purchase insurance, their insurer must include the mandated substance abuse treatment coverage in the policy.

Petitioners would have this Court legislate a distinction between employee benefit plans which are insured "enough," and those which Petitioners characterize as "marginally" insured. They conclude the latter should be "treated" as though they are uninsured.[3] Nothing in the language or the legislative history of ERISA supports this fiction. Nothing in the *Metropolitan Life* decision contemplates such sophistry. Petitioners are transparently attempting to manufacture grounds for review by this Court where clearly none exist. This Court authoritatively put this issue to rest in the *Metropolitan Life* case.

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[3] Petition For Writ of Certiorari, pp 9-10.

B. MANDATED COVERAGE OF SUBSTANCE ABUSE TREATMENT ADDRESSES A SERIOUS PUBLIC HEALTH THREAT.

As in other states, substance abuse is a serious problem in Michigan. It is estimated that three-quarters of one million Michigan citizens need services for drug abuse problems. Approximately 600,000 of these are persons with problems related to alcohol use—360,000 of whom are considered alcoholics. The remaining 150,000 persons are misusing or abusing prescription and other drugs.[4]

In addition to causing incalculable human suffering, substance abuse causes staggering financial waste. Estimates put the losses due to absenteeism, health and welfare costs, property damage and accidents, and medical expenses resulting from alcohol and other drug abuse at nearly $2 billion annually in Michigan alone. Lost productivity exceeds $700 million annually in Michigan.[5]

Prior to 1982, Michigan attempted to address this problem in part by requiring insurers writing policies in Michigan to *offer* to provide coverage for inpatient and outpatient treatment of alcoholism and drug abuse, but the coverage was not required. 1974 Public Acts of Michigan 50. This is commonly referred to as a mandatory offer law.

After years of trial, the Michigan legislature concluded that "The mandatory offer laws, in effect since 1974, have not

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[4]

Michigan Comprehensive State Plan for 1980-81, Office of Substance Abuse Services of Michigan, Department of Public Health, July 1980, pp 52-62.

[5]

Economic Costs to the State of Michigan for Alcohol and Drug Abuse and Mental Illness – 1982, California Health Research Foundation, 1982, "Introduction and Summary."

significantly increased the number of persons with coverage for substance abuse care, and a more forceful approach is necessary: mandatory coverage."[6] It was anticipated that mandatory coverage would prompt persons to seek treatment at earlier stages.

> "Not only does this mean that the treatment will be less expensive than if left until acute secondary problems arise, but it means the person seeking treatment stands a better chance of avoiding the loss of income and the family strife which often accompany advanced stages of substance abuse. Effective early diagnosis and treatment of substance abuse would eliminate the need for acute care and hospitalization later, thus reducing costs to the health care system."[7]

C. PETITIONERS' CLAIM THAT THE COURT OF APPEALS MISCONSTRUED THE METROPOLITAN LIFE DECISION IS BASELESS.

Petitioners have attempted to manufacture grounds for review by this Court where in fact none exist. Their contention that the Court of Appeals misconstrued this Court's decision in *Metropolitan Life, supra,* is fanciful. On the contrary, the decision of the Sixth Circuit is entirely consistent with the spirit and the letter of the *Metropolitan Life* case.

In that case, the insurers tried to convince this Court to adopt a narrow and "rather unnatural" interpretation of the ERISA saving clause based primarily on their view that it was unwise public policy to interpret that clause as written.

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[6] "Analysis of House Bills 4196 & 4197, as enrolled," Third Analysis, February 27, 1981, House Legislative Analysis Section.

[7] *Id.*

Although Congress saved from preemption "any law of any State which regulates insurance,"[8] the insurers contended that only "traditional" state insurance regulations avoided preemption.

This Court unanimously refused to impose limitations not evidenced by the statutory language or the legislative history.

> ". . . [N]othing in § 514(b)(2)(A), or in the 'deemer clause' which modifies it, purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind."
>
> 471 US ——; 105 S Ct at 2390; 85 L Ed 2d at 741.

Acknowledging that insured and uninsured plans are treated differently, and that nationwide employee benefit plans purchasing insurance may have to vary their benefits from jurisdiction to jurisdiction, this Court noted: "Arguments as to the wisdom of these policy choices must be directed at Congress." 471 US ——; 105 S Ct at 2393; 85 L Ed 2d at 745.

The Court of Appeals faithfully applied both the letter and spirit of the *Metropolitan Life* decision to the instant case. The Michigan statute requiring substance abuse treatment coverage, like the Massachusetts statute requiring mental health coverage, is undoubtedly a law which "regulates insurance" and, therefore, is saved from preemption. The Sixth Circuit correctly so held. Moreover, it correctly concluded that the law was no less saved from preemption because Petitioners

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[8] ERISA, § 514(b)(2)(A), 29 USC 1144(b)(2)(A).

retain some of the liability to pay benefits. Congress simply did not differentiate in § 514(b)(2)(A) between insurance laws regulating policies which are sold to fully insured plans and insurance laws regulating policies sold to plans which partially self-fund. If Petitioners find this common-sense application of the plain language of the saving clause to be unwise public policy, they can debate the wisdom of congressional choices in Congress. The Court of Appeals can hardly be faulted for following the lead of this Court and refusing to attribute to Congress an intention it nowhere indicated.

In fact, these Petitioners have at least three remedies available to them if they do not like the result in this case. First, they can prevail upon Congress to adopt their view of wise public policy and statutorily create the exception they ask this Court to manufacture. Second, they can convince the Michigan legislature to exempt them from the application of §§ 3425 and 3609a. Finally, they can simply elect to self-fund their entire program. It is not necessary (or appropriate) for this Court to adopt Petitioners' baseless interpretation of ERISA for Petitioners to avoid the logical consequence of the *Metropolitan Life* decision.

D. PETITIONERS WOULD HAVE THIS COURT LEGISLATE A DISTINCTION BETWEEN BENEFIT PLANS WHICH ARE INSURED ENOUGH, AND THOSE ADMITTEDLY INSURED PLANS, LIKE THEIRS, WHICH SUPPOSEDLY ARE NOT INSURED ENOUGH TO BE CONSIDERED "INSURED." THIS ANALYSIS IS UNSUPPORTED BY THE LANGUAGE OR LEGISLATIVE HISTORY OF ERISA AND CONTRADICTS THE WELL-ESTABLISHED RULE THAT PREEMPTION WILL NOT BE FOUND ABSENT UNMISTAKABLE CONGRESSIONAL INTENTION.

Ironically in the name of correcting the Sixth Circuit's supposed "distortion" of the difference between insured and uninsured plans, Petitioners would have this Court legislate a new distinction. Petitioners suggest that although their plans admittedly are insured, this Court should determine that they are not insured enough to be considered insured for purposes of ERISA preemption. This approach is unsupported by the language or legislative history of ERISA and contradicts the well-established rule that preemption will not be found absent unmistakable congressional intention to preempt.

To begin with, Petitioners have incorrectly framed the question in terms of whether they are insured or uninsured. The focus of an ERISA preemption inquiry, however, is not the employee benefit plan, but the state law allegedly preempted. If §§ 3425 and 3609a(2) "regulate insurance," they are saved from preemption by § 514(b)(2)(A). If they are saved from preemption, then Transamerica must comply and include the mandated coverage in its policies. Nowhere did Congress indicate that Transamerica's legal duty would vary depending upon whether it sold its insurance to fully insured plans or to plans which purportedly retain some of the liability themselves. The *Metropolitan Life* decision makes it undeniably plain that, like the Massachusetts mandated benefit law, the

Michigan mandated benefit law "regulates insurance" and so Transamerica must comply. That ends the inquiry.

Petitioners argue that their plans are separable into insured and uninsured components. In this view, they are insured only to the extent of Transamerica's obligation to pay claims above the claims liability limit. In all other respects, they argue, they are uninsured. Because Petitioners characterize the insurance as "marginal," they conclude they should be considered uninsured. Petitioners fail to support this analysis by reference to the language of § 514(b)(2)(A). Petitioners fail to support it by reference to the legislative history of ERISA. Instead, Petitioners rely upon 1982 amendments to ERISA which were expressly intended to reaffirm and strengthen the authority of the states to enforce their insurance regulations in the face of what Congress regarded as unwarranted ERISA preemption claims. Petitioners' argument is as unmeritorious after close examination as it appears at first glance.

In 1982, Congress amended the preemption language of ERISA with the express purpose of both clarifying *and strengthening* the authority of the states to enforce their insurance laws. Congress was concerned that ERISA's preemption language was being used by unscrupulous individuals to evade legitimate state insurance regulations. Typically, entrepreneurs would entice multiple small employers to participate in a trust established and administered by the entrepreneurs to provide health benefits at lower cost. These were commonly referred to as multiple employer trusts, or METs. Through incompetence, dishonesty or both, the trusts frequently became unable to pay claims and those very persons intended to be protected by ERISA, employee benefit plan participants and beneficiaries, were left with unpaid medical bills. State attempts to regulate these plans were hindered by the claim that the METs constituted ERISA plans and, therefore, the states could not enforce insurance regulations

against them due to the deemer clause, § 514(b)(2)(B). Some METs were ERISA plans. Others, the large majority, were not.[9]

Congress responded by clarifying and strengthening the authority of the states to deal with METs.[10] Congress reaffirmed its original intention that multiple employer welfare arrangements (essentially what had been known as METs) which did not qualify as employee welfare benefit plans under ERISA continued to be fully subject to applicable state regulations.

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[9]

This scenario was succinctly described by Rep. Phillip Burton in the *Congressional Record* as follows:

> "Although the Employee Retirement Income Security Act of 1974 (ERISA) was enacted to protect workers, some individuals have used ERISA as a smoke screen to conceal fraudulent activities.
>
> "These individuals approach employers, particularly small businesses, offering a cheaper alternative to traditional group health insurance coverage.
>
> "They set up trusts which they administer themselves to provide health coverage. But unlike licensed insurance carriers, they often fail to comply with the basic solvency controls which each State establishes to protect health care consumers.
>
> "When the State tries to enforce these controls, the trusts claim to be beyond the reach of State law because they are 'employee benefit plans' covered by Federal law.
>
> "By the time the U. S. Department of Labor decides if Federal law applies, the individuals who established the bogus insurance ventures have long since departed with the money and workers are left without any means of covering their unpaid medical bills."
>
> 128 Cong Rec H 9609 (daily ed. Dec. 13, 1982) (remarks of Rep. Burton in favor of § 302 of Pub Law 97-473 [96 Stat 2611] amending ERISA by adding § 514(b)(6), 29 USC 1144(b)(6)). See, also, 128 Cong Rec H 9610 (daily ed. Dec 13, 1982) (remarks of Rep. Erlenborn to the same effect).

[10]

Section 302 of P.L. 97-473 (96 Stat 2612) amending ERISA by adding § 3(40) and § 514(b)(6); 29 USC 1002(40) and 1144(b)(6).

> "The amendment reaffirms the original intent of Congress in enacting the Employee Retirement Income Security Act of 1974 (ERISA) that if a multiple employer welfare arrangement does not meet the definition of an employee welfare benefit plan under the act, then such an entity is not exempted — under the preemption provisions set forth in section 514 of ERISA — from the application of State insurance and other laws regulating such entities."
>
> 128 Cong Rec H 9610 (daily ed. Dec. 13, 1982) (remarks of Rep. Erlenborn).

In short, multiple employer welfare arrangements which are not also ERISA employee benefit plans have always been fully subject to all state laws.

But Congress also conferred *additional* authority on the states. Before the 1982 amendments, states could not apply their insurance regulations directly to METs which qualified as ERISA plans (even though a MET is essentially an insurance company) because the deemer clause prevented the states from treating employee benefit plans as insurers. By adding § 514(b)(6), Congress effectively weakened the deemer clause. It expressly permitted states to directly regulate even those METs which do qualify as ERISA employee benefit plans and, therefore, would otherwise be protected from state insurance laws by ERISA.

> "With respect to arrangements which meet the definition of ERISA plans, the amendment specifically permits State regulation in varying degrees depending on the type of arrangement and whether or not the arrangement is determined by the Department of Labor to be an ERISA covered welfare benefit plan. Thus the amendment removes any potential obstacle that might exist under current law which could hinder the ability of the States to

> regulate multiple employer welfare arrangements to assure the financial soundness and timely payment of benefits under such arrangements."
>
> 128 Cong Rec H 9610 (daily ed. Dec. 13, 1982) (remarks by Rep. Erlenborn).

What Congress did in 1982 then, was to clarify and strengthen the states' authority to regulate all multiple employer welfare arrangements. Those which do not qualify as ERISA plans have always been subject to direct state regulation. Those which do qualify as ERISA plans are nevertheless (and the deemer clause notwithstanding) subject to specified state regulation. Multiple employer welfare arrangements which are fully insured or which have been exempted by the Secretary of Labor, nevertheless must comply with state regulations providing "standards, requiring the maintenance of specified levels of reserves and specified levels of contributions," § 514(b)(6)(A)(i). All other multiple employer welfare arrangements which are ERISA plans must comply with "any law of any State which regulates insurance. . .to the extent not inconsistent with the preceding sections of this title." § 514(b)(6)(A)(ii).

In light of this background, Petitioners' reliance upon § 514(b)(6) is surprising, and plainly misplaced. That section is only relevant if state regulation of a multiple employer welfare arrangement which is also an ERISA employee welfare benefit plan is at issue. Although Petitioners claim to be ERISA employee benefit plans, they specifically do not claim

that they are multiple employer welfare arrangements.[11] Accordingly, § 514(b)(6) is entirely irrelevant to this case.

Moreover, it is undeniable that Congress specifically expressed its intention that the 1982 amendments did not address the question presented in this case, i.e., whether state-mandated benefit laws are preempted as to those insurance policies which an employee benefit plan elects to purchase.

> "This Senator might add that no provision of H.R. 5470 is intended either to overturn or endorse the decision reached by the U. S. Court of Appeals in Wadsworth, et al. against Whaland. . . ."
>
> 128 Cong Rec S 15988 (daily ed. Dec. 21, 1982) (remarks of Senator Dole).

The same sentiment had been expressed earlier in the House by Representative Burton:

> "Finally, neither sections 301 or 302 of this amendment are intended in any way either to overturn or endorse the decision of the U.S. First Circuit Court of Appeals in *Wadworth,* [sic] et al. v *Whaland* (562 F. 2d 70 1st Cir. 1977, cert denied, 435 U.S. 980 (1978), which held that

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[11]

Petition for Writ of Certiorari, p 11. The reason for this is apparent. If Petitioners were multiple employer welfare arrangements which qualify as ERISA employee welfare benefit plans, § 514(b)(6)(A)(ii) expressly authorizes the states to enforce directly against them "any law of any State which regulates insurance. . .not inconsistent with the preceding sections of this title." Therefore, Michigan could directly require Petitioners to provide the mandated substance abuse benefits, *even if Petitioners were entirely self-funded.* In the present circumstances, of course, the state is attempting no such regulation. Michigan is only requiring Transamerica to include mandated substance abuse coverage in its policies. If Petitioners elect to purchase those policies, they must necessarily purchase the substance abuse coverage as well.

> a New Hampshire insurance law regulating the content of group insurance policies sold to ERISA covered welfare plans was not preempted under section 514 of ERISA. Resolution of that issue should be dealt with in separate legislation after a full opportunity for both sides to present their views."
>
> 128 Cong Rec H 9609 (daily ed. Dec. 13, 1982) (remarks of Rep. Burton).

Finally, if Petitioners are suggesting that, although it is not directly applicable, § 514(b)(6) is indicative of some obscure congressional intention to distinguish generally between fully insured and partially insured employee benefit plans, they are twice wrong. First, given the legislative history sketched above, it is clear that Congress was addressing a specific problem which had arisen as a result of unwarranted claims of ERISA preemption. There is nothing to indicate an intention to diminish state regulation of partially insured plans. Second, this Court has repeatedly stated that preemption will not be found "in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained." *Alessi* v *Raybestos-Manhattan, Inc*, 451 US 504, 522; 101 S Ct 1895, 1905; 68 L Ed 2d 402, 416 (1981) (quoting from *Florida Lime & Avocado Growers* v *Paul*, 373 US 132, 142; 83 S Ct 1210, 1217; 10 L Ed 2d 248, 257 (1963)). Vague "suggestions" from inapplicable sections of ERISA fall substantially short of meeting this standard.

CONCLUSION

For the foregoing reasons, this Court should deny the petition for writ of certiorari.

Respectfully submitted,

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C. SECTIONS 514(a), 514(b)(1), 514(b)(2) AND 514(b)(6) OF ERISA, 29 USC 1144(a), 1144(b)(1), 1144(b)(2) AND 1144(b)(6), AS AMENDED BY § 302 OF P.L. 97-473 (96 STAT 2612) 4a

A. Section 3425 of the Michigan Insurance Code of 1956; MCLA 500.3425; MSA 24.13425, as added by 1980 Public Acts of Michigan 429.

Section 3425. (1) Required coverage. Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for group and individual hospital, medical, surgical expense-incurred health insurance policies other than limited classification policies.

(2) Option to decline coverage. In the case of group health insurance policies, if the premium for a group health insurance policy would be increased by 3% or more because of the provision of the coverage required under subsection (1), the master policyholder shall have the option to decline the coverage required to be provided under subsection (1). In the case of individual health insurance policies, if the total premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).

(3) Charges, terms, conditions. Charges, terms, and conditions for the coverage required to be provided under subsection (1) shall not be less favorable than the maximum prescribed for any other comparable service.

(4) Reduction of coverage by policy terms and conditions; deductibles and copayment. The coverage required to be provided under subsection (1) shall not be reduced by terms or conditions which apply to other items of coverage in a health insurance policy, group or individual. This subsection shall not be construed to prohibit health insurance policies

that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse.

(5) Minimum benefits. The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to $1,500.00 in benefits for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(6) Definitions. As used in this section:

(a) "Health insurance policy" means a hospital, medical, or surgical expense incurred policy.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individual physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(d) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(e) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

(7) Effective date. This section shall take effect January 1, 1982.

B. Section 3609a of the Michigan Insurance Code of 1956; MCLA 500.3609a; MSA 24.13609a, as added by 1980 Public Acts of Michigan 429.

Sec. 3609a. (1) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in that policy a provision that the insurer will provide coverage for inpatient care for substance abuse to the extent agreed upon between the insured employer

or other insured organization and the insurer, to be provided in a facility approved by the department of public health for hospitalization or treatment of substance abuse. This coverage shall be subject to the provisions of sections 3406 to 3466, except section 3425.

(2) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall include in that policy a provision that the insurer will provide coverage for intermediate and outpatient care for substance abuse, to the extent required by section 3425.

(3) This section shall take effect January 1, 1982.

C. Sections 514(a), 514(b)(1), 514(b)(2) and 514(b)(6) of ERISA, 29 USC 1144(a), 1144(b)(1), 1144(b)(2) and 1144(b)(6), as amended by § 302 of P.L. 97-473 (96 Stat 2612).

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(6)(A) Notwithstanding any other provision of this section —

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall effect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.